Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL MRI & DIAGNOSTICS

Respondent Name
BITUMINOUS CASUALTY CORP

MFDR Tracking Number
M4-13-3169-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier denied the CPT codes as charges included in another charge or service. Per the EMG CPT Code 2012 the new EMG codes must be used when NCV and EMG are performed together."

Amount in Dispute: $853.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is medical fee dispute regarding charges billed under CPT Codes 95903 & 95904 for service date February 8, 2012. Carrier denied reimbursement on the basis the services billed under those codes are not reimbursed when billed in conjunction with were [sic] CPT 95861. Attached is a memorandum from the bill reviewer, Corvel, that sets out the authority for this bill reduction. Carrier maintains that additional reimbursement is not owed."

Response Submitted by: FLAHIVE, OGDEN & LATSON

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2012	CPT Codes 95903 and 95904	$853.52	$ 853.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional fees.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision maintained.
   - 97 – Charge included in another charge or service.
   - R89 – CCI: Misuse of Column 2 code with Column 1 code.

Issues

1. Did the requestor bill correctly?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The disputed services, CPT Codes 95903, defined as "Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study" and 95904 defined as "Nerve conduction, amplitude and latency/velocity study, each nerve; sensory" were denied as 97 – "Charge included in another charge or service" and R89 – "CCI: Misuse of Column 2 code with Column 1 code." Review of the CCI edits for the codes billed finds there are no CCI conflicts. Therefore the respondent's denials are not supported.
2. Review of the submitted diagnostic study report finds the services were rendered as billed. Therefore reimbursement is recommended as follows:
   - CPT Code 95903 – (54.96 ÷ $34.0376) x $75.41 x 4 units = $486.16
   - CPT Code 95904 – (54.96 ÷ $34.0376) x $59.98 x 6 units = $580.03

   The requestor is seeking $367.36.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $853.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $853.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 10, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.